LETTERS TO THE EDITOR

Retrospective study of male lichen sclerosus and outcome in Leicester: 1995–9 inclusive: experience of a genitourinary medicine clinic

EDITOR,—We have studied retrospectively 76 male cases of lichen sclerosus (LS) (formerly called balanitis xerotica obliterans), that presented over the period 1995–9 inclusive, in Leicester.

These cases were predominantly diagnosed on clinical grounds by experienced clinicians with eight (10.5%) proved by a biopsy.

A clinical diagnosis was made from the presence of combinations of clinical features.

From the literature it can be found that LS is the commonest cause of meatal stenosis in adults and children.[1] Most men present with a phimosis so may require circumcision.[1] Complications include meatal or urethral stricture and some lesions progress to malignancy.[1]

The fact that LS of male genitalia can involve the anterior urethra is highlighted by Barbagli *et al*.[2] In their series of LS cases there was external meatus involvement in 19%, fossa navicularis in 16%, penile urethra in 3%, and notably panurethral disease in 52%.[2]

Nasca *et al* found that malignant changes were associated with 5.8% of the cases of penile LS in their series of 86 patents from Catania and Rome.[3] They emphasise that patients with genital LS are at considerable risk for the development of penile squamous cell carcinoma, as well as verrucous carcinoma and erythroplasia of Queyrat.[3] They also suspect that epithelial dysplasia per se may be precancerous.[3] Reports in general on LS from GUM clinics are rare; notably Bingham reported a solitary malignancy in LS in 1978 from a GUM clinic in a 39 year old man.[4]

Recent studies on LS have shown that susceptibility to the disease may be partly genetically predetermined by having certain human leucocyte antigens—namely, class II loci HLAs, DQ7, or DR11.[5] Also, Clifton *et al*[6] have recently postulated that there is evidence for the loss of androgen receptors with disease progression in LS; thus supporting a hormonal pathogenesis of LS. This assertion also provides a rationale for the use of testosterone creams in LS.

In Leicester, we have found that there is a tendency for cases to be referred to dermatologists and/or urologists early, and they are therefore lost to follow up by the GUM clinic. Eighty eight per cent of the men were white, with 9.2% being Asian; 84% were lost to follow up as at the year 2000, with 17% and 18% referred to dermatologists or urologists at any time respectively. Eighty four per cent used 1% hydrocortisone cream at any time; steroids creams stronger than 1% hydrocortisone were used in 21.1% of the cohort and 92.1% of the cohort were uncircumcised. Early referral means that procedures—for example, meatotomy or urethroplasty or therapeutic circumcision, are not recorded often in GUM notes. There was also a tendency for dermatology or urology not to "update" the GUM clinic with time. Despite this, phimosis was found in 40.8% with meatal stricture in 19.7%, therapeutic circumcision in 15.8%, and malignancy in one case. Anterior urethral involvement was present in only 7.9% in our series, meaning that it may represent a late stage phenomenon. Biopsies were found to be 100% confirmatory of diagnosis of LS—that is, 8/8 biopsies done.

One must conclude that a multidisciplinary approach to LS care should continue to operate, and that long term follow up is mandatory.

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Accepted for publication 12 September 2000

Chaperoning male patients

EDITOR,—Torrance *et al* reported on genitourinary physicians' experience in the use of chaperones in clinics of genitourinary medicine,[1] and Bignell broadened the debate and suggested further study of whether male genital examinations should be more frequently chaperoned.[2] We have carried out a small prospective questionnaire study of new male patients inquiring both about the sex of the examining doctor and the preference for a chaperone.

In all, 94 patients were questioned by either KB or CM following clinical examination. Eighty six patients were examined by a male doctor, and eight by a female doctor. Two of the male doctor's patients would have preferred a female doctor, but none of the female doctor's patients, although small in number, would have preferred a male. Fifty two patients were chaperoned and one patient subsequently decided he would have preferred not to have been. None of the 42 unchaperoned patients would have preferred a chaperone to be present, and the sex of the chaperone did not appear to be important, although in this small study a female chaperone was present with a female doctor on only two occasions.

Table 1

	Sex of chaperone		*No chaperone (%)*
	Male (%)	*Female (%)*	
Sex of doctor			
Male	13 (100%)	32 (97%)*	41 (100%)
Female	5 (100%)	2 (100%)	1 (100%)

*Represents one patient.

The number and percentage of patients who were satisfied to be examined with a chaperone present according to the sex of the doctor and the chaperone, are summarised in table 1.

In conclusion, it appears in this study that our male patients generally feel comfortable with genital examinations by doctors of either sex, and they do not express the desire for a chaperone to be present. We obviously have not addressed the issue of whether or not it may be desirable from the doctor's point of view for a chaperone to be present.[3]

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Accepted for publication 12 September 2000

Ciprofloxacin 250 mg for treating gonococcal urethritis and cervicitis

EDITOR,—In the recently published UK national guidelines on sexually transmitted infections and closely related conditions[1] ciprofloxacin 500 mg orally as a single dose has been recommended for uncomplicated anogenital infection due to *Neisseria gonorrhoeae* in adults. However, some studies have shown that an oral dose of 250 mg of ciprofloxacin is an effective treatment for uncomplicated gonorrhoea.[2 3]

In our department, we have been using ciprofloxacin 250 mg as a single oral dose as first line treatment for uncomplicated gonococcal urethritis and cervicitis and 500 mg of oral dose of ciprofloxacin for rectal and pharyngeal infections since 1997. We reviewed case notes of patients with uncomplicated gonococcal infections who attended our department between 1 January 1999 and 31 December 1999. A total of 61 patients with a positive culture were analysed. Of the 61 patients 42 patients with gonococcal urethritis and cervicitis were treated with ciprofloxacin 250 mg as a single oral dose. Eleven patients were treated with 500 mg of ciprofloxacin. Of the 11 patients five had rectal or pharyngeal infections, two were infected with a strain less sensitive to ciprofloxacin, four were initially treated with 250 mg of ciprofloxacin and subsequently given 500 mg of ciprofloxacin when rectal/pharyngeal cultures were found to be positive. Five patients with pregnancy or risk of pregnancy were treated with 3 g amoxycillin with 1 g probenecid and three patients (two pregnant patients with history of allergy to penicillin and one patient infected with a strain resistant to penicillin and less sensitive to ciprofloxacin) were treated with 2 g of intramuscular spectinomycin. In the group treated with 250 mg of ciprofloxacin, 35 (83%) patients, and in the groups treated with 500 mg ciprofloxacin, amoxycillin, and